THE TRANSMISSION OF EPIDEMIC INFLUENZA
R Edgar Hope-Simpson
Plenum Publishing Corporation, New York (1992)
251 pages. Price US$45.00

At a recent international meeting on influenza, I told an American colleague that I had been given this book to review. He commented that it was an honour and privilege to be given the task and continued to praise its author Edgar Hope-Simpson. Hope-Simpson has a worldwide reputation for his lifetime's work and that has led him to formulate a new concept for the transmission of influenza which is outlined in this book.

In his new concept, he challenges conventional thinking that influenza spreads directly from infected to non-infected persons. Painstakingly, Hope-Simpson draws on historical and contemporary opinion which questions the acceptibility of the hypothesis of direct spread. He cites, for example, the sudden and widespread appearance of the epidemic of 1775 which was researched by John Fothergill. Hope-Simpson undertook his research by maintaining regular correspondence with a network of medical observers throughout the United Kingdom — the model of a modern weekly return service. He recalls his own early practice experience in rural Dorset in 1932 where he was struck by the dramatic and sudden nature of the onset of an influenza outbreak in scattered rural communities. The discovery of an influenza virus infecting humans in 1933 gave rise to further doubts. What happened to the virus between epidemics? Could it somehow persist in a non-infectious mode? Why did epidemics seem to swing between the southern and northern hemispheres? Why did epidemics end, even when there were non-immune persons in the community who could contract the illness?

From these background questions, Hope-Simpson elaborates on his detailed practice experience of studying influenza in families. For many years he has monitored influenza clinically and supported his observations with appropriate virological investigation. He proposes that influenza is introduced into a household by a symptomless carrier of virus from a previous epidemic whose potential for infectiousness has been reactivated by external factors. Among the factors he includes season which he links to the intensity of solar radiation. He offers explanations for both antigenic drift and antigenic shift and considers the concepts in relation to non-human influenza epidemics and to relevant experimental work.

This is primarily a book for those particularly interested in influenza. However, every practice library should contain one or two books like this. It is a paradigm for potential researchers — detailed literature search, meticulous observation, careful consideration of all relevant facts, a new hypothesis proposed and carefully examined, all presented in a quality of English language which in itself is an example to us.

D M FLEMING
Director, Birmingham research unit, Royal College of General Practitioners

DIGEST

This month ● patient satisfaction ● euthanasia ● prescribing ● asthma

Measuring patient satisfaction

CONSUMERISM and audit have underlined the importance of patient satisfaction as an objective and as an outcome of health care. In order to assess patient satisfaction and produce evidence sufficient to support change, reliable, valid tools must be applied. Richard Baker has developed two patient questionnaires, one referring to the last consultation and the other to the general practice surgery, which score components of satisfaction, such as accessibility and professional care, on five-point scales.

Existing data suggest that dissatisfied patients are more likely than satisfied patients to change general practices and less likely to have experienced continuity of care. To test whether the new questionnaires correlate with these concepts (or constructs), they were first sent to 400 patients who had moved from a general practice but not changed their home address (movers), and secondly, to 869 randomly selected patients from two practice lists (non-movers). The 68% of movers who replied were significantly less satisfied with their previous general practice than the 82% of respondents in the non-mover group were with their general practice. The movers were also significantly less satisfied with their last consultation. Non-movers were subdivided according to whether they had seen their usual doctor in the majority of their previous 12 consultations. Non-significant differences were as predicted (greater continuity of care corresponding with greater satisfaction) for the majority of components of satisfaction. A third of non-movers were asked to repeat the questionnaire a fortnight later; 55% responded, and produced similar scores, thereby confirming good test–retest reliability.

The authors conclude that the questionnaires are reliable and valid and should be preferred to untested tools. However, the constructs are mainly based on practice in the United States of America and may be inappropriate in the United Kingdom. Furthermore, although continuity is addressed by both questionnaires, its relationship with satisfaction is complex. In addition, the two groups were dissimilar in age, a factor which has strong associations with satisfaction. These timely questionnaires merit further validation and thus more widespread use.

SIMON GRIFFIN
Research fellow, Department of Primary Medical Care, University of Southampton

Source: Baker R, Whitfield M. Measuring patient satisfaction: a test of construct validity. *Qual Hlth Care* 1992; **1**: 104-109.

Euthanasia and assisted suicide

IN the last decade, much philosophical and ethical debate has occurred about the practice of euthanasia and assisted suicide by health professionals. This Dutch study aimed to determine the extent to which it is practised by family doctors and to assess the prudence of their actions.

The survey was conducted using an anonymous postal questionnaire, to which 67% (1042) of the randomly selected doctors responded. Although euthanasia or assisted suicide was practised about 2000 times every year by this sample, approximately half of them had never engaged in its practice, and the patients' requests for the procedure were complied with in only 40% of cases. Most often it was the patient who initiated a discussion of euthanasia or assisted suicide, and the commonest reason for such a request was to escape 'pointless suffering'. In